TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DALLAS COUNTY HOSPITAL

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-15-3241-01

Carrier's Austin Representative
Box Number 09

MFDR Date Received
June 01, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is supplemental to Part V of the attached for mDWC-60, and will serve as PARKLAND HOSPITAL "Requestor's Rationale for Increased Reimbursement or Refund." This dispute originated with YORK RISK SERVICES (hereinafter Carrier) denial of the above referenced claim based upon the assertion that the Claimant's presenting concerns did not constitute an emergency. Regarding this matter PARKLAND HOSPTIAL (hereinafter Requestor) would show the following:

The attached claim was processed and paid by your company on 12/01/2014 However, the reimbursement issued was significantly below the current Division of Workers' Compensation prescribed fee schedule. The MAR (Maximum Allowable Reimbursement should be calculated at 143 percent of Medicare's Inpatient Prospective Payment System (IPPS) rate in accordance with 28 TEX. ADMIN.CODE §134.404(f)."

Amount in Dispute: $8,709.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in regards to the Medical Dispute Request from Parkland Hospital for services on 08/13/2014. The provider is stating the bill was underpaid by $87090.06. The provider submitted a DRG calculation where they are showing the amount to be paid. Wellcomp used the same DRG Inpatient Calculator to determine reimbursement as well. The issue at hand is the provider is using the reimbursement amount of $$24,284.29 x 143% for the amount to bill. The provider isn't taking the uncom care into account in their calculation. Medicare #450015. DRG 935"

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2014 to August 17, 2014	Inpatient Hospital Services	$8,709.06	$8,709.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 class of contract code identification segment (Loop 2100 other claim related information rep). If adjustment is at the line level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment: (Loop 2110 Service payment information REF) if the regulation apply. To be used for Workers' Compensation only.

Issues

1. The respondent raised an issue of uncom care in its response, shall the issue be considered in accordance with 28 Texas Administrative Code §133.307?
2. Is the issue of uncom care part of the calculation in accordance with 28 Texas Administrative Code §134.404?
3. What is the applicable rule for determining reimbursement of the disputed services?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. Per §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

   In the carrier response the carrier states "This letter is in regards to the Medical Dispute Request from Parkland Hospital for services on 08/13/2014. The provider is stating the bill was underpaid by $87090.06. The provider submitted a DRG calculation where they are showing the amount to be paid. Wellcomp used the same DRG inpatient Calculator to determine reimbursement as well. The issue at hand is the provider is using the reimbursement amount of $$24,284.29 x 143% for the amount to bill. The provider isn't taking the uncom care into account in their calculation. Medicare#450015. DRG 935 $23072.27 – uncom care amount $1044.80 = $12625.47 x 143% = $18054.42. Wellcomp disagrees with the provider and feel we overpaid the bill by $6229.87." Originally, the carrier did not address the issue of uncom care in the explanation of benefits only in the carrier's response dated July 10, 2015. Therefore, a new issue will not be considered in accordance with Per §133.307(d)(2)(F).

2. Review of the carrier response states "The provider isn't taking the uncom care into account in their calculation. Medicare#450015. DRG 935 $23072.27 – uncom care amount $1044.80 = $12625.47 x 143% = $18054.42. Wellcomp disagrees with the provider and feel we overpaid the bill by $6229.87."

   The uncom care issue addressed is included in the reimbursement calculation in accordance with 28 Texas Administrative Code §134.404.

3. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS)

reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

4. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 935. The services were provided at DALLAS COUNTY HOSPITAL. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $23,072.27. This amount multiplied by 143% results in a MAR of $32,993.335.
5. The total recommended payment for the services in dispute is $32,993.35. This amount less the amount previously paid by the insurance carrier of $24,284.29 leaves an amount due to the requestor of $8,709.06. The requestor is seeking $8,709.06. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $8,709.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $8,709.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		8/7/15
Signature	Medical Fee Dispute Resolution Officer	Date
		8/7/15
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.